Instructions for Mississippi Medicaid Part B Crossover Claim Form (06/10)
For Part C Claims ONLY

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (06/10)
1	Required	**Provider Name and Address**: Enter the full name and address of the provider/facility submitting the claim.
2a	Optional	**Medicaid Provider Number:** Enter the 8 digit Medicaid number of the health care provider.
2b	Required	**National Provider Identifier (NPI):** Enter the 10 digit NPI number of the health care provider who is to receive payment for the service(s).
2c	Required if Applicable	**Taxonomy Code:** Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
3	Required	**Beneficiary Name and Address:** Enter the full name (last name, first name) and the address of the beneficiary receiving services.
4	Required	**Beneficiary Medicaid ID Number:** Enter the 9 digit Medicaid ID number assigned to the beneficiary receiving the service.
5	Optional	**Patient Account/Medical Record Number:** Enter the internal account number or medical record number of the beneficiary.
6	Required	**Diagnosis Code:** Enter up to 4 (ICD-9) diagnosis codes (beginning with primary) related to the billing period.
7	Required	**Service Dates:** Enter the from and thru date of service for this billing in MM/DD/CCYY format.
8	Required	**Procedure Code:** **Outpatient Services:** Enter the HCPCS code for laboratory, radiology and dialysis services provided. **Professional services**: Enter the appropriate CPT code for the services provided.
9	Required	**Procedure Modifier**: Enter the applicable modifier for the procedure rendered.
10	Required	**Service Units:** Enter the number of units provided on each detail line.
11	Required	**Medicare Billed Charges:** Enter the total charges (dollars.cents) billed to Medicare for each detail line.
12	Required	**Medicare Allowed Amount:** Enter the amount payable for each service (dollars.cents) as determined by Medicare.
13	Required	**Medicare Non-covered Amount:** Enter the charge (dollars.cents) for any non-covered service, such as take-home drugs.
14	Required	**Blood Deductible Amount:** Enter the total Medicare deductible amount (dollars.cents) for blood which is to be paid

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (06/10)
		by Medicaid.
15	**Required**	**Medicare Paid Amount:** Enter the total amount (dollars.cents) Medicare paid on the claim for each detail line.
16	**Required**	**Medicare Deductible:** Enter the total Medicare deductible (dollars.cents) amount which is to be paid by Medicaid.
17	**Required**	**Medicare Coinsurance:** Enter the total Medicare coinsurance amount (dollars.cents) to be paid by Medicaid.
18	**Required**	**Medicare Paid Date:** Enter the date of Medicare payment in MM/DD/CCYY format.
19	**Required if Applicable**	**Third Party Payment Amount:** Enter the amount (dollars.cents) of payment made by any third party source applied toward the claim for each detail.
20	**Required**	**Provider Signature:** The provider or an authorized representative must sign the claim form. Rubber stamp signatures are acceptable.
21	**Required**	**Billing Date:** Enter the date the claim was submitted to the Medicaid fiscal agent for processing in MM/DD/CCYY format.

Medicare Part B

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	2c. Taxonomy Code	3. Recipient Name and Address
	2b. NPI Number		

4. Recipient Medicaid ID	5. Patient Account/ Medical Record Nummber

6. Diagnosis	
Primary	Secondary
3rd	4th

	7. Service Dates From	Thru	8. Procedure Code	9.Modifer	10. Service Units	11. Medicare Billed Charges	12. Medicare Allowed Amount
	13. Medicare Non-Covered Amt.	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-insurance	18. Medicare Paid Date	19. Third Party Amount
1							
2							
3							
4							
5							
6							

I certify that the foregoing information is true, accurate, and complete and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

20. Provider Signature	21. Billing Date

Revised 06/16/10 rre